January 10, 2003

Re: Medical Dispute Resolution
MDR #: M2-03-0263-01-SS
IRO Certificate No.: IRO 5055

Dear:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced below, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic/Spine Medicine.

I am ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by __ is deemed to be a Commission decision and order.

Clinical History:
This male claimant suffered an on-the-job injury on ___. He underwent a discectomy on 08/07/00 and has presented with increasing and severe back and left lower extremity pain.

Disputed Services:
Anterior and posterior fusion at L4-5 and L5-S1.

Decision:
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the procedure in question is not medically necessary in this case.

Rationale for Decision:
This patient has severe back and left lower extremity pain. He has failed conservative measures including physical therapy, injections

and medications. An MRI scan dated 07/22/02 revealed degenerative discs at L4-5 and L5-S1, and a possible recurrent left-sided L4-5 herniated disc. Flexion/extension fluoroscopy performed on 08/14/02 revealed spondylolisthesis at L4-5 and L5-S1.

It is unclear at this point what the contributing factors to this patient's severe back and left lower extremity pain may be. Until this diagnostic information is obtained in this case, anterior and posterior fusion at L4-5 and L5-S1 is not medically necessary.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on January 10, 2003.

Sincerely,